## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2011 FORM APPROVED OMB NO. 0938-0391

	R MEDICARE & MEDIC		erra)	mrn. n	NAME AND ADDRESS OF THE PARTY O		IB NO. 0938-0391
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMP	
		152028	B. WIN			09/28/2	2011
					ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF I	PROVIDER OR SUPPLIEI	R		9509 G	EORGIA ST		
VIBRA H	OSPITAL OF NOR	THWESTERN INDIANA			N POINT, IN46307		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B)	IATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	IATE	DATE
S0000							
	This visit was fo	or a standard licensure	SO	000			
	survey.						
	Facility Number	012121					
	racinty Number	. 012131					
	Survey Date: 09	9/27-28/2011					
	Surveyors:						
	ReBecca Lair, L	CSW					
	Medical Surveyo						
	Jacqueline Brow	n PN					
	^						
	Public Health N	urse Surveyor					
	Lynnette Smith						
	Laboratorian/Me	edical Surveyor					
	QA: claughlin 1	0/17/11					
	271. Claugiiiii i						
	I		I				I

 $LABORATORY\ DIRECTOR'S\ OR\ PROVIDER/SUPPLIER\ REPRESENTATIVE'S\ SIGNATURE$ 

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

AND PLAN OF CORRECTION ID		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152028	A. BUILDING		OO	(X3) DATE : COMPL 09/28/2	ETED
		102020	B. WING	DEET AF	DDRESS, CITY, STATE, ZIP CODE	00/20/2	011
NAME OF P	ROVIDER OR SUPPLIER				ORGIA ST		
VIBRA H	OSPITAL OF NORT	THWESTERN INDIANA			POINT, IN46307		
(X4) ID		FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TA	.G	DEFICIENCY)		DATE
S0362	410 IAC 15-1.4-1( (E)(F						
	<ul><li>(d) The governing board is responsible for assuring that quality patient care is provided. In accordance with hospital policy, the governing board shall do the following:</li><li>6) Ensure that the hospital does the following:</li></ul>						
	procurement. (C) Inform families persons of potential donors of the optic admission or at the potential donor. (D) Use discretion contacts with potentialies. (E) Notify the approganization of potential donors.	licies and facilitation of fonations, including for authorized al organ and tissue on of donation on the time of death of a and sensitivity in antial organ donor forpriate procurement tential organ the organ transplantation					
	Based on docume interview, the go ensure forms for organ and tissue accurately for 3 c	ent review and staff verning board failed to identifying potential donors were completed of 3 (N10, N11 and N13) edical records reviewed	S0362		Inservice by Regional Gift of Hope Coordinator provided to Director of Quality on 10/13/1 This included guidelines on completing the form and reviet the required reporting requirements and monthly au Director of Quality and Chief	o I1. ew of udits.	11/21/2011

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
ANDILAN	or conduction	152028		LDING	00	09/28/2	
		102020	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/20/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	EORGIA ST		
VIBRA H	OSPITAL OF NORT	THWESTERN INDIANA			N POINT, IN46307		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	,		DATE
	and failed to notify the appropriate organ procurement organization, per contract, of all hospital deaths.				Clinical Officer provided 1:1 training for nursing staff rega		
					proper completion of the Gift		
					Hope form and required time	lines	
	Findings.				for notification. 100% death review audit to ensure		
	Findings:  1. Review of closed patient medical				compliance and proper		
		PM on 9/27/11, indicated			documentation. Audit results	s to	
	patient:	i ivi on 9/2//11, illulcated			be reported to the Quality	rain a	
	1 *	on 4/7/11 and the form			Committee for tracking, analy and trending and quarterly to	-	
	_	mpleted for Every			Medical Executive Committe		
	•				and the Governing Board.		
	Imminent Death and Expiration":  A. lacked a date and time of				Responsible Party is the Dire		
		The Supervisor in the			of Quality. Completion date November 21, 2011.	IS	
	Outcome section	-			11010111201 21, 2011.		
		ras contacted from the					
	Gift of Hope and						
	_	iver in section A. "Patient					
	1 '	r[organ and/or tissue					
		hen the checkbox in					
	1 ^ -	nt is NOT a candidate for					
		cornea donation" was					
	marked.						
	C. section B.	was also filled out with					
	who was contact	ed from the Gift of Hope.					
	b. N11 expired	on $4/13/11$ and the form					
	titled, "To be Co	mpleted for Every					
	Imminent Death	and Expiration":					
	A. lacked wha	at the outcome was;					
	Supervisor authe	ntication; and a date and					
	time of authentic	ation of the Supervisor in					
	the Outcome sec	tion.					
	B. had who w	ras contacted from the					
	Gift of Hope and	the name of the					
	family/consent g	iver in section A. "Patient					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  152028		A. BUI	LDING	NSTRUCTION 00	r ′	E SURVEY LETED 2011	
		102020	B. WIN		DDDESS CITY STATE 7ID CODE	00/20/	2011
NAME OF F	PROVIDER OR SUPPLIER				.DDRESS, CITY, STATE, ZIP CODE EORGIA ST		
VIBRA H	OSPITAL OF NORT	THWESTERN INDIANA			N POINT, IN46307		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI	BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
	IS a candidate fo	r[organ and/or tissue					
	procurement]" w	hen the checkbox in					
	section B. "Patie	nt is NOT a candidate for					
	organ, tissue or c	cornea donation" was					
	marked.						
		was also filled out with					
		ed from the Gift of Hope.					
	_	on 6/26/11 and the form					
		mpleted for Every					
	Imminent Death	*					
		at the outcome was;					
	-	ntication; and a date and					
		ation of the Supervisor in					
	the Outcome sec						
		ras contacted from the					
	_	ection A. "Patient IS a					
	_	organ and/or tissue					
	^ -	hen the checkbox in					
		nt is NOT a candidate for					
	marked.	cornea donation" was					
		was also filled out with					
	who was comact	ed from the Gift of Hope.					
	2 Personnel D16	) was interviewed on					
		AM and confirmed the					
		ination of organ and					
		ent were not completed					
	accurately as des	•					
	1	l patients who expired.					
		r r r					
	3. Review of th	e contract between the					
	hospital and the	Gift of Hope Organ &					
	Tissue Donor Ne	etwork, indicated the					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 152028		(X2) MUL A. BUILD		STRUCTION 00	(X3) DATE S COMPLI	ETED	
		152028	B. WING			09/28/20	)11
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
VIBRA H	OSPITAL OF NORT	HWESTERN INDIANA			POINT, IN46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PF	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
	hospital shall pro death or imminer	vide "All notification of nt death".					
	Scorecard for the death occurred in	nation Activity Report year 2010 indicated 1 December 2010, ths were reported for					
	3. Interview with Employee #A3 on September 28, 2011 at 2pm, at which time review of the Gift of Hope contract documentation and the December 2010 data verified the information.						
S0556		an active, en hospital-wide rogram. Included in be system designed n, surveillance, rol, and prevention ommunicable					
	Based on policy a document review facility failed to in hospital-wide infi per policy and pr	and procedure review, r, and staff interview, the implement its fection control program ocedure related to munization status and/or	S055	56	All new employees are obtain a post-offer/pre-employment history and physical including screening of immunization stand/or history of such. The Employee Health Coordinator is responfor reviewing the results prior	atus sible	11/21/2011

AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  152028		LDING	NSTRUCTION 00	(X3) DATE COMPI 09/28/2	LETED	
	PROVIDER OR SUPPLIEF	THWESTERN INDIANA	 9509 GE	DDRESS, CITY, STATE, ZIP CODE EORGIA ST N POINT, IN46307	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	personnel health  Findings:  1. Policy titled, Profile" reviewed 9/28/11, indicate a. on pg. 1, und point 7., "Emplot addresses TB (tu screening. Various vaccine history, histories and con local, state and fragencies."  2. Review of pe 8:30 AM on 9/28 a. Personnel P2 documentation of and/or history Various vaccine history vaccine history, histories and con local, state and fragencies."  2. Review of pe 8:30 AM on 9/28 a. Personnel P2 documentation of and/or history Various vaccine history, histories and con local, state and fragencies."  2. Review of pe 8:30 AM on 9/28 a. Personnel P2 documentation of and/or history Various vaccine history, histories and con local, state and fragencies."  2. Review of pe 8:30 AM on 9/28 a. Personnel P2 documentation of and/or history Various vaccine history, histories and con local, state and fragencies."  2. Review of pe 8:30 AM on 9/28 a. Personnel P2 documentation of and/or history Various vaccine history, histories and con local, state and fragencies."	der Procedures section, yee Health Profile berculosis) testing and/or ella history, Hepatitis B and immunization applies with all applicable ederal regulatory  rsonnel health records at 8/11, indicated: 2, P8, and P9 lacked f immunization status aricella. Personnel P2 and History Questionnaire ation statement that they sox and was signed only not a physician. 8 lacked documentation status and/or history for 6 lacked documentation status and/or history for 8 was interviewed on		employment and ensuring immunization status and/o history is documented. Cuemployee files are being reto ensure immunization stand/or history is document. Those non-compliant will be directed to an occupational center to obtain titers or a suphysician history of status. Responsible Party is the Irr. Control Coordinator. Com Date November 21, 2011.	rrent eviewed tus ed. e I health erified The fection	
	9/28/11 at 10:06	AM, and confirmed				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION (X3) DATE SURVEY  COMPLETED		SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00		
		152028	B. WIN	G		09/28/20	011
	PROVIDER OR SUPPLIER	THWESTERN INDIANA		9509 GI	ADDRESS, CITY, STATE, ZIP CODE EORGIA ST N POINT, IN46307		
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TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
S0952	and/or history wa	f the immunization status as lacking as described entioned personnel.					
	medications shall accordance with s medical staff polic If the blood transfu intravenous medicadministered by pophysicians, the pespecial training for in accordance with Based on review policies and procand staff intervieensure blood transduministered in a policies and procadministered in a poli	ersonnel other than resonnel shall have these procedures a subsection (b)(6). of blood administration redures, patient records, w, the hospital failed to asfusions were accordance with approved redures for 10 of 10 eviewed.	S0	952	The Blood Product Administre Policy has been revised to address vital sign documents and timeliness in accordance state law and medical staff policies and procedures and be presented at the Medical Executive Committee follower the Governing Board. Traning Staff occurred 1:1 beginning October 8 and was reinforce ongoing and presented at two staff meetings in October. The staff nurse notifies the Direct Quality or designee when a beta transfusion is ordered and the above information is reviewed and subsequently audited by Director of Quality for complitation in the Company of the Compan	eation e with will ed by ng of d o he cor of plood ee d o the ance,	11/21/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  152028		LDING	NSTRUCTION 00	` ′	E SURVEY PLETED /2011	
	PROVIDER OR SUPPLIEF	THWESTERN INDIANA	STREET A	.DDRESS, CITY, STATE, ZIP COL EORGIA ST N POINT, IN46307	Ε	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	which read:  a. "Prior to o Blood Bank asse pre-transfusion of the transfusion of the transfusion of the transfusion of the transfusion of transfusion completed transfusion completed transfusion completed transfusion completed transfusion of transfusion of the following:  a. Patient #L 5-28-11 and discipation for the following:  a. Patient #L 5-28-11 and discipation for the following:  a. Patient #L 5-28-11 and discipation for the following:  between 10:00 A the following:  a. Patient #L 5-28-11 and discipation for the following:  a. Patient #L 5-28-11 and discipation for the following:  between 10:00 A the following:  a. Patient #L 5-28-11 and discipation for the following:  a. Patient #L 5-28-11 and discipation for the following:  a. Patient #L 5-28-11 and discipation for the following:  between 10:00 A the following:  a. Patient #L 5-28-11 and discipation for the following:  a. Patient #L 5-28-11 and discipation for the following:  between 10:00 A the following:  a. Patient #L 5-28-11 and discipation for the following:  a. Patient #L 5-28-11 and discipation for the following:  between 10:00 A the following:  a. Patient #L 5-28-11 and discipation for the following:  between 10:00 A the following:  a. Patient #L 5-28-11 and discipation for the following:  between 10:00 A the following:  a. Patient #L 5-28-11 and discipation for the following:  between 10:00 A the following:  a. Patient #L 5-28-11 and discipation for the following:  between 10:00 A the following:  a. Patient #L 5-28-11 and discipation for the following:  between 10:00 A the following:  a. Patient #L 5-28-11 and discipation for the following:  between 10:00 A the following:  a. Patient #L 5-28-11 and discipation for the following:  between 10:00 A the following:  a. Patient #L 5-28-11 and discipation for the following:  between 10:00 A the following:  between 10:00 A the following:  between 10:00 A the following:  a. Patient #L 5-28-11 and discipation for the following:  between 10:00 A the following:  between 10:00 A the following:  between 10:	btaining blood from ess patient and obtain vital signs. Vital signs ithin 30 minutes of the fusion." In patient vital signs berature, pulse, blood pressure)15 Int of transfusion45 Int of transfusion2 hours sfusion3 hours after bonone hour post bletion" Insfusions are completed s of blood product		Clinical Officer and Dire Quality are responsible of the blood transfusion compliance with policy procedure of blood trans Blood product administ documentation will be r Quality monthly, Medic Executive Committee q followed by the Govern	ector of for audit s and and sfusions. ration eported to al	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI	LTIPLE CO	NSTRUCTION		(X3) DATE COMPL	
AND PLAN	OF CORRECTION	152028		A. BUILI	DING	00		09/28/2	
		132020		B. WING				09/20/2	011
NAME OF P	ROVIDER OR SUPPLIER	₹					STATE, ZIP CODE		
VIDDALL		THWESTERN INDIANA				EORGIA ST N POINT, IN4	6207		
					CROW	N POINT, IN4	0307		
(X4) ID		TATEMENT OF DEFICIENCIES		_	ID		R'S PLAN OF CORRECTION CTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		P	REFIX TAG	CROSS-REFERE	ENCED TO THE APPROPRIATE DEFICIENCY)	ГЕ	COMPLETION DATE
TAG					TAG		DEFICIENCE)		DATE
		after it was removed from							
		Fifteen minute vital signs							
		340", 10 minutes after the							
		ted. Vital signs were not							
		minutes, one hour, and							
		he start of the transfusion,							
		oproved policies and							
	procedures. The								
	•	5-11 at "0200", 4 hours							
		after the blood was							
		ne blood bank. One hour							
	•	vital signs were taken at							
	4:00 AM, two ho	ours after the transfusion							
	was completed.	The first unit of FFP was							
	issued on 6-13-1	1 at "2250" and the							
	transfusion initia	ated at "2230", 40 minutes							
	after the FFP wa	s removed from the blood							
	bank. The secon	nd unit of FFP was issued							
	on 6-13-11 at "22	250" and the transfusion							
	initiated at "0016	6" on 6-14-11, 1 hour and							
	26 minutes after	the unit was removed							
	from the blood b	ank. Vital signs were							
		45 minutes after the start							
	of the transfusion	n, as required by							
		es and procedures. The							
		completed at "0105" and							
		nnsfusion vital signs were							
	•	<i>I</i> on 6-14-11, 2 hours and							
		the transfusion was							
	completed.								
	•	2 was admitted on 6-9-11							
		on 7-1-11. The patient							
	_	of LR PRBC's. The first							
		R PRBC's was initiated on							
FORM CMS-2	567(02-99) Previous Version		ıт\	L /H11	Facility 1	ID: 012131	If continuation sl	neet Pa	ge 9 of 16

Page 9 of 16

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  152028		ĺ	LDING	nstruction 00	(X3) DATE : COMPL 09/28/2	ETED
NAME OF	DROWNER OF GUIDE TER				DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			9509 G	EORGIA ST		
VIBRA H	OSPITAL OF NOR	THWESTERN INDIANA		CROWN	N POINT, IN46307		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
IAG		)". Pre-transfusion vital		TAG	DEFICIENC!)		DATE
	_	at "0835", 45 minutes of the transfusion. Vital					
	•	ocumented 45 minutes					
	and one hour after						
		equired by approved					
		cedures. The second unit					
		as issued from the blood					
		M", and the transfusion					
		5", 1 hour and 25 minutes					
		vas removed from the					
	blood bank.						
	c. Patient #L:	3 was admitted on					
	3-25-11 and disc	harged on 5-6-11. The					
		3 units of LR PRBC's and					
	one unit of FFP.	The first unit of LR					
	PRBC's was initi	iated on 4-5-11 at "2245"					
	and completed o	n 4-6-11 at "0200". Vital					
	signs were not de	ocumented 45 minutes,					
	one hour, 2 hour	s, and 3 hours after the					
	transfusion was s	started, as required by					
	approved policie	s and procedures. One					
	•	ision vital signs were					
		1, 2 hours after the					
		completed. The second					
		C's was issued from the					
		-6-11 at "1224". The time					
		vas initiated was not					
	documented. It						
		e transfusion was initiated					
		es of the time of issue,					
		ot the 15 minute and					
	_	s signs were taken in the					
	timeframe requir	red by approved policies					

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIE		(X2) MU	LTIPLE CO	NSTRUCTION		(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMI	BER:	A. BUILI	DING	00		COMPL	
		152028		B. WING				09/28/2	U11
NAME OF I	PROVIDER OR SUPPLIE	R				ADDRESS, CITY, STA	ATE, ZIP CODE		
\/IDDA I I	OCDITAL OF NOD	TUNA/COTEDALINDIA	A N I A			EORGIA ST	0.7		
		THWESTERN INDIA				N POINT, IN463	07		
(X4) ID		STATEMENT OF DEFICIEN			ID		PLAN OF CORRECTION VE ACTION SHOULD BE		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED R LSC IDENTIFYING INFO		l I	PREFIX TAG	CROSS-REFERENCE	ED TO THE APPROPRIAT	E	COMPLETION DATE
1710		The transfusion w			1710				DATE
	_	00 PM". The third							
		issued from the blo							
		at "2225" and the	50 <b>u</b>						
		ated on 4-6-11 at "0	)255"						
		ninutes after the blo							
		om the blood bank.							
		ocumented 45 min							
	and 2 hours after		utes						
		equired by approve	d						
		cedures. The transf							
		at "0535", 6 hours a							
	_	e unit was removed							
	the blood bank.		HOIII						
	transfusion vital	-							
		required by approv	ed						
		cedures. The unit of							
	-	the blood bank on							
		e transfusion was in							
		ransfusion vital sig							
		535", 45 minutes b							
		was initiated. Vital							
		ented 45 minutes a	•						
		ansfusion was initia							
		oved policies and	,						
		e hour post transfus	sion						
	-	documented at 9:00							
	_	minutes after the	,						
	transfusion was	completed.							
		4 was admitted on							
		charged on 8-12-11							
		2 units of LR PRB							
	-	of LR PRBC's was							
	from the blood bank on 8-9-11 at "1:45								
FORM CMS-2	2567(02-99) Previous Versi	ions Obsolete	Event ID: J	ITVH11	Facility l	D: 012131	If continuation sh	neet Par	ge 11 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  152028		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION  00	(X3) DATE : COMPL 09/28/2	ETED	
NAME OF I	PROVIDER OR SUPPLIEF	<u> </u>	p. (VII)		ADDRESS, CITY, STATE, ZIP CODE		
					EORGIA ST		
		THWESTERN INDIANA		<u> </u>	N POINT, IN46307		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	,	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	PM" and the transfusion initiated at						
	"1445", one hou	r after it was removed					
	from the blood b	ank. The unit was					
	completed at "15	515" and the one hour					
	post transfusion	vital signs taken at					
	"1600", 45 minu	tes afte the transfusion					
	was completed.						
	e. Patient #L	5 was admitted on					
	4-21-11 and disc	charged on 6-3-11. The					
	^	2 units of LR PRBC's.					
		s initiated on 4-23-11 at					
	"4:15 PM". Vita	•					
		minutes, one hour, 2					
	· ·	rs after the transfusion					
		equired by approved					
		cedures. The transfusion					
	•	t "8:00 PM", 4 hours and					
		the blood was removed					
		ank. One hour post					
	transfusion vital	· ·					
		ne second unit of LR					
		red from the blood bank					
		549" and the transfusion					
		2030", 4 hours and 41 was removed from the					
		al signs were not minutes, one hour, and 2					
		ansfusion was started, as					
		oved policies and					
		transfusion was					
	^	300", 7 hours and 11					
	-	blood was removed from					
	the blood bank.	orood was removed from					
		6 was admitted on 5-5-11					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  152028			A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00			(X3) DATE SURVEY  COMPLETED  09/28/2011			
152028			B. WI				U3/28/2	UTI		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE						
VIBRA HOSPITAL OF NORTHWESTERN INDIANA					EORGIA ST N POINT, IN463	07				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION			(X5)		
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		E	COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEF	ICIENCI)		DATE		
		on 6-22-11. The patient								
		of LR PRBC's. The first								
		C's was issued from the								
		-21-11 at "6:37 PM" and								
		nitiated at "1940", 1 hours								
		fter the blood was								
		ne blood bank. Vital signs								
		ented 45 minutes, one								
		nd 3 hours after the								
		started, as required by								
	approved policies and procedures.									
	Instead, vital signs were documented at									
		00". The transfusion was								
	completed at "2300", 4 hours and 21									
		e blood was removed from								
		The one hour post								
		e, respirations, and blood								
	•	ot documented, as								
		coved policies and								
	-	procedures. The second unit of LR								
		PRBC's was released from the blood bank								
		:37 PM" and the								
		ated at "2315", 4 hours								
		after the blood was								
		ne blood bank. The 45								
	_	spirations, and blood								
	1 *	ot documented. Vital								
	signs were not d	ocumented 1 hour and 2								
	hours after the tr	ransfusion was started, as								
		roved policies and								
	_	e transfusion was								
	completed at "02	completed at "0200", 7 hours and 23								
		e blood was released from								
	the blood bank.	The one hour post								
FORM CMS-2	2567(02-99) Previous Versi	ions Obsolete Event ID:	JTVH1	1 Facility I	D: 012131	If continuation sh	neet Pa	ge 13 of 16		

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152028		MULTIPLE CONSTRUCTION  UILDING  ING		(X3) DATE SURVEY COMPLETED 09/28/2011		
NAME OF PROVIDER OR SUPPLIER  VIBRA HOSPITAL OF NORTHWESTERN INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE  9509 GEORGIA ST  CROWN POINT, IN46307					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE	
	policies and proc g. Patient #L 6-27-11 and disc patient received. The second unit from the blood b "21:45" and the to 7-13-11 at "2415 minutes after the the blood bank. signs were taken 30 minutes after from the blood b minutes prior to approved policie transfusion was of hours and 30 min removed from the g. Patient #L 5-20-11 and disc patient received. The first transfus initiated on 6-5- were not docume hour after the star required by appreprocedures. The completed at "21 transfusion vital documented. The PRBC's was issue	required by approved sedures.  7 was admitted on harged on 8-14-11. The 2 units of LR PRBC's. of LR PRBC's was issued ank on 7-12-11 at transfusion initiated on 7. 2 hours and 30 blood was removed from Pre-transfusion vital at "2415", 2 hours and the blood was issued ank, not within 30 release, as required by s and procedures. The completed at "0215", 4 nutes after the blood was e blood bank.  8 was admitted on harged on 6-15-11. The 2 units of LR PRBC's. Sion of PR RBC's was 11 at "1758". Vital signs ented 45 minutes and one art of the transfusion, as oved policies and transfusion was 35". One hour post						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152028	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 09/28/2011		
			P. WIII		DDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					EORGIA ST		
VIBRA HOSPITAL OF NORTHWESTERN INDIANA				CROWN	N POINT, IN46307		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
TAG		· · · · · · · · · · · · · · · · · · ·		TAG	BETTEIENCTY		DATE
		15", 4 hours and 15 blood was removed from					
		Vital signs were not					
		_					
	documented 45 minutes, one hour, and 2 hours after the transfusion was started, as						
		oved policies and					
	procedures. The	-					
	_	30" 7 hours after the					
	*						
	blood was removed from the blood bank.						
	One hour post transfusion vital signs were not documented.						
	h. Patient #L9 was admitted on 8-9-11						
	and discharged on 8-31-11. The patient						
	received one unit of LR PRBC's. The unit						
	was issued from the blood bank on						
	8-12-11 at "1700" and the transfusion						
		0", 3 hours and 40					
		blood was removed from					
		Fifteen minute vitals					
	signs were taken at "2100", 20 minutes after the transfusion was initiated. Vital signs were not documented 45 minutes, one hour, 2 hours, and 3 hours after the transfusion was started, as required by approved policies and procedures. The transfusion was completed at "0040", 7						
		nutes after the unit was					
	removed from th	e blood bank. One hour					
	post transfusion	vital signs were not					
	documented.  i. Patient #L10 was admitted on						
	4-15-11 and disc	harged on 5-6-11. The					
	patient received	2 units of LR PRBC's.					
	The first unit of	LR PRBC's was issued					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 152028		A. BUI	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  D. WING		(X3) DATE SURVEY  COMPLETED  09/28/2011		
		.52526	B. WIN		DDDEGG CITY OF ATT	CODE	J G , L G , Z ,	- · ·
NAME OF PROVIDER OR SUPPLIER				1	DDRESS, CITY, STATE, ZIP EORGIA ST	CODE		
VIBRA HOSPITAL OF NORTHWESTERN INDIANA					I POINT, IN46307			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			(X5)
PREFIX	,	CY MUST BE PERCEDED BY FULL		PREFIX				COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)			DATE
		ank on 4-20-11 at "1123"						
		on was initiated at "11:55						
		fusion vital signs were						
		55 minutes prior to the						
		fusion, not within 30						
	minutes prior to							
		equired by approved						
		cedures. Vital signs were						
		45 minutes and one hour						
		the transfusion, as						
		oved policies and						
	procedures. The	transfusion was						
	completed at "12	240" and one hour post						
	transfusion vital	signs were not						
	documented. Th	e second unit of LR						
	PRBC's was issu	ed from the blood bank						
	on 4-20-11 at "1	123" and the transfusion						
	initiated at "12:4	0", 1 hour and 17						
		unit was removed from						
	the blood bank.	Vital signs were not						
		ninutes after the start of						
		as required by approved						
		cedures. The transfusion						
		t "1325", and one hour						
	post transfusion vital signs were not							
	documented, as a	_						
	do outronous, us	oquin ou.						
	3 In interview o	on 9-28-11 between 12:30						
		aff Member #L23						
	· · · · · · · · · · · · · · · · · · ·	ne above findings.						
	acknowledged th	ic above midnigs.						
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	<u> </u> JTVH11	Facility II	D: <b>012131</b> If co	ontinuation she	et Par	ne 16 of 16